CASE # 19 CV 5472 (GRB)(AYS)

JUDGE SHIELDS:

DATE 11-15-19

IN RESPONSE TO ORDER DATED Oct 24th 2019 I AM REQUESTING AN EXTENTION OF TIME OF APPROXIMATELY SIX MONTH OR TILL IM OUT OF REHAB FACILITY CURRENTLY IM IN COLD SPRING HILL CENTER AND ATTACHING LETTER OF MY DAY OUT TO COME HERE INDED TO BE BACK THERE I WAS ABLE TO COME OUT FOR TODAY ONLY ONCE I AM OUT I PLAN TO SEE PRO SE CLINIC AS I DONT HAVE FUND TO HIRE ATTORNEY

SINCERLY THANKFUL

PAUL MULLER JR

CC PLAINTIFF

MY ADDRESS
106 STEAMBOAT RD
GREAT NECK NY 11024

COLD SPRING HILLS
CENTER FOR NURSING & REHABILITATION

378 Syosset-Woodbury Road . Woodbury, NY 11797

RESIDENT: [illegible]

ROOM: [illegible]

OUT ON PASS SUMMARY

This form is to be completed and signed only after a Physician's Order has been written.

☐ **Day Pass**
☐ Escorted ☐ Unescorted
☐ **Therapeutic Leave (Overnight)**
☐ Escorted ☐ Unescorted

Escorted Pass or Therapeutic Leave
Responsible Party: ☐ _____ **Relationship:** _____
Address: _____
Destination address: _____ Telephone #: _____
Date and time of departure: _____
Date and time of anticipated return: _____

Unescorted Pass or Therapeutic Leave
Responsible Party: ☐ Resident: _____ Relationship: Self
Address: _____
Destination address: _____ Telephone #: _____
Date and time of departure: _____
Date and time of anticipated return: _____

I understand the terms of this pass agreement and that if I do not comply, future out on pass requests may be denied.
If you require any assistance while you are out on pass or therapeutic leave, please contact Cold Spring Hills Center for Nursing & Rehab at (516) 921-3900 and ask for the Nursing Supervisor.

In the event of a medical emergency, call "911".

I release Cold Spring Hills Center of Nursing & Rehabilitation, its directors, officers, personnel and agents, and my attending and treating physician(s), from any and all liability for any and all consequences including any accident mishap or deterioration of condtion, while off premises.
I have received the following: ☐ medication ☐ equipment ☐ patient/caregiver education
☐ Resident has Cold Spring Hills ID bracelet in place. ☐ Resident has copy of non hospital DNR if appropriate.

By signing this form, I acknowledge that if I do not return to Cold Spring Hills Center for Nursing and Rehabilitation by the expected date and time of my return, this document can become a signed "Leaving Against Medical Advice" form and may forfeit my residential rights at Cold Spring Hills Center for Nursing and Rehabilitation

_____ _____
Responsible Party/ Date **Licensed Nurse/Date**

Distribution: Original-Chart, Pink-Responsible Party/Resident, Yellow- Receptionist/Security at Front Desk